

The Michael Stone Inquiry – A Reflection¹

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On 9th July 1996 Lin Russell and her two young daughters, Megan and Josie, were subjected to an horrific assault with a hammer after being tied up. All but Josie were killed, and she was badly injured. The attack took place in broad daylight in a peaceful country lane and was perpetrated by someone completely unknown to them. The encounter was clearly a random chance bringing together an entirely innocent and happy family with someone bent on terrible violence. Not surprisingly these events triggered a wave of national horror. This turned to anger when, Michael Stone, a man with a history of mental disorder, drug abuse and violence was arrested, over a year later, following information passed to the police by his psychiatrist in response to a *Crimewatch* reconstruction.

Mr Stone denied any involvement in these crimes, a denial he maintains in spite of his conviction, after a trial, a retrial, and the rejection of his final appeal. The case was marked by the absence of forensic evidence and the Crown's reliance on allegations of confessions made to cell-mates.

Following the initial conviction, an inquiry was set up in accordance with government policy requiring such an investigation following a homicide committed by a person in receipt of mental health services.³ The initial terms of reference included three stages, fact-finding, evaluation and policy. In the event it was not practicable to proceed to the third stage.⁴ To produce a properly informed consideration of the policy implications of the case it would have been necessary to publish the report on the first two stages. The protracted nature of the appeal process in the criminal proceedings made this impossible within a reasonable timescale.⁵

It would have been difficult to find a person with a background more likely to fuel a debate about the protection of society from dangerously disordered individuals than Mr Stone. He had spent much of his childhood in institutional care. There was a history of drug abuse. After convictions as a teenager for offences of dishonesty and one of arson, he went on to be convicted of a number of offences of robbery, and assault for which he was sent to prison. In 1987 he was sentenced to 8½ years imprisonment for offences of robbery, possession of a firearm, burglary and theft. The sentencing judge is reported to have described him as “*an extremely dangerous man*”, and a probation officer described him in 1991 as “*the most dangerous man I have dealt with*”. In 1994 he was convicted of burglary and unlawful possession of a gun, for which a probation order was made. He was compulsorily admitted to a mental hospital for a short period later in the same year. Between his discharge from section 3 detention and the murders, a period

1 The author chaired the Independent Inquiry into the Care and Treatment of Michael Stone, and as such was co-author of its report. While this article contains a summary of some of the findings of the inquiry, that summary and any other views expressed in this article are his personal views and responsibility.

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3 For the policy at the time see Circular HSG(94)27

4 South East Coast Strategic Health Authority et al, Report of the Independent Inquiry into the Care and Treatment of Michael Stone, September 2006 p 2. The report was delivered to the commissioning agencies in November 2000.

5 *ibid* p 374

of 17 months, he was in constant contact with statutory agencies. He was recorded as having told various professionals of homicidal thoughts. On at least two occasions he was alleged to have said that he felt like killing children, on another that he had wanted to stab someone, on yet another that he had been making explicit threats about decapitating children. Shortly before the Russell murders he was said to have expressed a threat to kill a probation officer and rape his wife.

Mr Stone's initial conviction for the murders was met with conflicting official responses. The statutory services who had been responsible for providing him with mental health, drug addiction, probation and social services issued a statement, which had been subjected to amendment by the Department of Health, and, it has been suggested, by the Prime Minister's spokesperson,⁶ at the end of the trial from the courthouse steps. Mr Stone was, it was emphasised, not mentally ill, but someone with an anti-social personality disorder who had abused multiple drugs for a long time. He was responsible for his own actions, and in answer to the question of whether he was "mad" or "bad", he was not mad. The statement denied that Mr Stone had been ignored by the statutory agencies or had requested in-patient treatment for which he was rejected. On the other hand the Liberal Democrats and the Government, as represented by the Home Secretary, Mr Jack Straw, attributed responsibility for cases such as this to the psychiatric profession in refusing to accept that patients such as Mr Stone were treatable, and therefore detainable, under the Mental Health Act 1983. Mr Alan Beith MP asked the Home Secretary the following question:⁷

Does the Home Secretary believe that further measures will be needed to deal with offenders who are deemed to be extremely violent because of mental illness or personality disorder, but whom psychiatrists diagnose as not likely to respond to treatment? Is he aware that this concern has arisen not simply following the conviction of Michael Stone for those two brutal and horrible murders, but because there has been a tendency in recent years for psychiatrists to diagnose a number of violent people as not likely to respond to treatment?

Mr Straw replied:

Sir Louis Blom-Cooper, who has a distinguished record in this field, said on the radio on Sunday that one of the problems that has arisen is a change in the practice of the psychiatric profession which, 20 years ago, adopted what I would call a common-sense approach to serious and dangerous persistent offenders, but these days goes for a much narrower interpretation of the law. Quite extraordinarily for a medical profession, the psychiatric profession has said that it will take on only patients whom it regards as treatable. If that philosophy applied anywhere else in medicine, no progress would be made in medicine. It is time that the psychiatric profession seriously examined its own practices and tried to modernise them in a way that it has so far failed to do.

The divide between those who favour treatability as the correct criterion for detention under mental health legislation, and those who consider that the availability of treatment, in its broadest sense, should allow detention when the public requires protection from a dangerous individual, continues in the present parliamentary debate on the current Mental Health Bill. The extent to which Mr Stone's case informs the debate is also in dispute. Thus Lord Carlile of Berriew said recently:⁸

I want to say one thing about the Mental Health Bill. We know that the Government intend to introduce a new Bill, which is merely an amendment of the Mental Health Act 1983. I plead with them that we

6 Rutherford, *Dangerous People: Beginnings of A New Labour Proposal in Newburn & Rock* (ed), *The Politics of Crime Control*, 2006, OUP, pp 73-74

7 Hansard (HC) vol 319, col 9, 26 October 1998

8 Hansard (HL) (60612-22) 12th June 2006 col 95

should not find ourselves getting bogged down in the Michael Stone question all over again. Mental health is not about a small number of people who unfortunately are not cured, are released from hospital, possibly by mistake or maybe by negligence, and commit terrible acts. It is tough to say so, but we can say it in this place because we are not elected: those kinds of accidents happen from time to time. We must talk about the real questions in mental health and not the headline questions, such as Michael Stone.

And Lord Patel said in later debate:⁹

The medical profession, particularly the Royal College of Psychiatrists, is very concerned about the way that some politicians, members of the Government and parts of the media have linked the need for new mental health legislation with violence. Major problems with the mental health services include lack of trained staff, unpleasant in-patient environments, and lack of funding for research on both the causes of mental illness and potential treatments. ...

Neither the most recent homicide report on the care and treatment of John Barrett, which highlighted significant failings in the system, nor the inquiry into the case of Michael Stone, which was highly influential in directing the Government's development of this legislation, recommended any new legislation.

There is a widespread perception among the general public that violence, and homicide in particular, are rising problems caused by the introduction of care in the community and loopholes in the current Mental Health Act. That assumption makes good tabloid headlines but is incorrect.

The official opposition health spokesperson in the Lords said:¹⁰

All sorts of new programmes and treatments have been developed in recent years to help many people with personality disorders. To the extent that such people are gaining access to these programmes, it is hard to see what the problem is. If such people are being denied access to those programmes, that surely is not a fault of the law or of definitions; it is either because of resources or because clinicians have misunderstood the law. The remedy for either of those things does not lie in amending the legislation. One high-profile example is the inquiry into the Michael Stone case, which did not recommend that the law needed to be changed. It criticised a number of things, but criticised in particular the lack of hospital beds in medium secure units. The amount and the intensity of care that Stone received were, in fact, considerable.

Lord Soley disagreeing with this, said:¹¹

The Front Bench opposite referred to the Stone case. Michael Stone had had previous psychiatric treatment, but when he went back to another hospital and asked to be readmitted because he would do something very damaging or dangerous otherwise, he was refused. This was a common experience for probation officers and other people who were working in this area in the 1970s. It has remained so since then. Although I have left the profession, plenty of contacts tell me of instances—although there are fewer of them—of people who are refused admission or treatment because their condition is regarded as not treatable. This is a major problem.

Thus both sides of the argument appear to want to use the case of Mr Stone as supporting their argument. Therefore it is an opportune moment to reflect on what, if anything, can be drawn from the case to assist the current debate.

9 Hansard(HL) (28th November 2006 (pt 6) col 686-687

11 *ibid* col 299

10 Hansard (HL) 10th January 2007 col 297

Mr Stone presented with a number of problems which included a severe antisocial personality disorder, multiple drug and alcohol abuse and occasional psychotic symptoms consistent with having been induced by the drug abuse, or his personality disorder. Much about him remains unknown in spite of a searching inquiry, and the conscientious efforts of the many professionals who saw him over the years. Thus it was only at the inquiry that it was discovered that Mr Stone had been visiting more than one general practitioner under a different names. This lack of information was compounded by the way in which he would appear to different professionals. Thus to some he would appear to be very threatening while at almost the same time he would appear compliant and to be genuinely seeking help. He would issue blood-curdling threats and express terrible things he claimed to want to do, but usually in the context of expressing dissatisfaction with some aspect of his medication. It must have been very difficult to evaluate whether he meant what he said or whether he merely said such things for effect.

Mr Stone was not someone who was ignored by statutory services and left to his own devices, Indeed the range of services he received and the intensity with which they were provided was remarkable, particularly given the lack of any real progress with him. For example, in the 17 month period leading up to the murders, Mr Stone was seen approximately 20 times by staff in the addiction services. In the same period he was seen by staff of the local forensic psychiatric unit about 18 times. Between August 1995 and April 1996, when his probation order expired, Mr Stone was seen about 19 times by a probation officer. The inquiry report doubted that much more would have been done for Mr Stone anywhere else in the country at the time.

However there were questions over the effectiveness of what was done. The community mental health services showed a reluctance to acknowledge that it had a role in the care of someone considered to be dangerous, apart from seeking to persuade others of the danger. The addiction service failed to provide adequate planning or implementation of a coherent and proactive programme of rehabilitation. In particular Mr Stone's requests for in-patient detoxification were ignored. In contrast the forensic psychiatric service was judged to have provided conscientious and accurate assessments of Mr Stone and offered continuous contact with a skilled community psychiatric nurse. Contrary to some media reports at the time, there was no question of the forensic service refusing to admit Mr Stone to hospital. Indeed they went beyond their remit on one occasion by offering in-patient detoxification when other units were unwilling or unavailable to do so.

One failing pervaded virtually all service contacts with Mr Stone: a failure to apply the Care Programme Approach effectively so as to ensure that all interventions and programmes were coordinated, leading to a lack of clarity of purpose and coordination.

The most striking matter for criticism concerned events on 4th and 5th July 1996. Mr Stone was recorded as having become angry in the presence of a community psychiatric nurse and threatened to kill a probation officer. The incident was reported to the consultant forensic psychiatrist who directed that inquiries be made of various people to ascertain more about Mr Stone's mental state. Among these, Mr Stone's general practitioner was to be asked about the depot medication being given. When asked about this, the general practitioner did not inform the forensic services that Mr Stone was overdue for his depot, or give an accurate account of the medication he, the general practitioner, was prescribing and administering. The consultant told the inquiry that if he had known that Mr Stone had missed his injection and had become aggressive, he might have considered that as a rationale for treating Mr Stone under the Mental Health Act. As he was never confronted with that information he did not know what his decision would in fact have been; he might have felt that the known stability of the depot medication in the blood was such that this could not be an explanation of any deterioration in behaviour. Indeed the

inquiry made it clear that it did not find that delays in receipt of depot medication had any significant adverse clinical effect on Mr Stone.¹² As it was, he was assured that there was no such problem and therefore he did not deem it necessary to see Mr Stone for assessment.

In the context of the debate on mental health reform occurring since the inquiry, the core issue appears to be the issue of treatability as a criterion for compulsory admission to hospital. The Government's argument appears to be that this is used as an excuse to avoid admission. The opposite view is that people should not be admitted to hospital unless there is something beneficial which can be done for them by way of treatment and care. The consultant forensic psychiatrist to whom the aggressive outburst of 4th July was reported, described his thinking in relation to Mr Stone in clear terms:

If he had been off the Haldol and there were clear mental illness symptoms which had just emerged, then, yes, that would push me into use of the Mental Health Act for reasons of mental illness. That would be fairly clear... where he is off the Haldol and there is aggression and volatility, yes, I guess that would have given some rationale for treatability, some reasonably short-term prospect of treating the aggression in his personality disorder, bringing it down from a certain level to a somewhat lower level. So there would have been a therapeutic prospect for an admission.

Listening down the phone to what [the community psychiatric nurse] was telling me, I was waiting, I suppose, for some reason to take particular courses of action, something that could usefully be done. If one of the many things she might have said was, "Actually he has got worse recently, the two or three times I have seen him and he actually is more paranoid than he used to be and he has told me today that he has not been along to the surgery for his Haldol", then a way forward emerges. There is a picture of a temporary deterioration. It might be regarded as in some ways an element of mental illness or at least a treatable component of personality disorder, but there was nothing like that...

...I did not see how compulsory treatment could change a personality disorder that was so long ingrained, and, in particular, I did not see how compulsory treatment could change his attitude to drug use. So even if we did manage to successfully contain any attempts of his to abscond or escape, on past form he would return immediately, or rapidly at least, to the same lifestyle with all the same risks, having gained no benefit from any admission. The last part of what I imagined was that that would then mean that any detention on the grounds of personality disorder would be an indefinite detention.

... there is no definition of treatability in the Mental Health Act, and in practice every psychiatrist has to think of a patient's treatability in the unit to which they have access, admission under them, or admission to the unit under discussion, the proposed admission, when a mental health assessment has been called for. So I was thinking about treatability in my unit.¹³

The inquiry in effect accepted that this psychiatrist's judgment on this patient was correct and that there was no justification under the law as it then stood for compulsory admission. The reasoning of the consultant suggests that the issues with which those proposing reform have to grapple must include:

- Is compulsory detention in a medical facility appropriate or justifiable for someone whose behaviour is principally caused by his voluntary abuse of illegal drugs or an unchangeable personality disorder?
- Should detention in a medical facility be restricted to those facilities which have a regime of treatment or care which is likely to bring about some beneficial change in the subject's behaviour or condition?

12 Report Chapter 6 paragraph 20.1

13 Quoted from the Report, chapter 9, paragraph 8.13

- If so, should detention of some other sort be available where no such facilities exist?
- Alternatively is it acceptable to detain a person in a medical facility even where there is no prospect of effecting beneficial change, other than separating the individual from the public?

Understandably the focus of governmental and public concern is on the danger posed to the public by people such as Mr Stone, and on how the public may be protected from them. Since the inquiry there have been a number of reforms to the sentencing powers of the criminal courts, principally in the Criminal Justice Act 2003. These include a wider range of circumstances in which indeterminate sentences can be handed out, and a greater focus in sentencing on risk and danger. For example a life sentence or imprisonment for public protection must be imposed in respect of convictions for specified serious offences if certain conditions are fulfilled.¹⁴ One of the conditions is that the court

*Is of the opinion that there is a significant risk to members of the public of serious harm occasioned by the commission by him of further specified offences.*¹⁵

There is a rebuttable presumption that there is such a risk in the case of an offender over the age of 18 who has been previously convicted of one or more relevant offences.¹⁶

These changes have led to recent expressions of concern at the increase in the numbers of prisoners on indeterminate sentences and the difficulties involved in processing their assessment for release.¹⁷ In January this year the Home Secretary urged the courts to send fewer offenders to prison. He said that the courts should not be

*...squandering taxpayers' money to monitor non-dangerous and less serious offenders... the public have a right to expect protection from violent and dangerous offenders... Prisons are an expensive resource that should be used to protect the public and to rehabilitate inmates and stop them reoffending.*¹⁸

More recently the Prison Governors Association

*has warned that a substantial overuse of new "indeterminate" sentences is creating chaos, and that inflexible "breach" procedures that see released offenders "whisked back into custody" for being late for appointments is driving prison numbers up.*¹⁹

This admittedly early experience may suggest that there is a difficulty in pin-pointing precisely which offenders present the risk of significant harm which requires indeterminate detention in order to protect the public. The same difficulty is likely to attach to use of mental health legislation for the same purpose.

Section 3 of the Mental Health Act 1983 currently contains the following requirements as to condition for admission:

- (1) *A patient may be admitted to a hospital and detained there for the period allowed by the following provisions of this Act ... in pursuance of an application made in accordance with this section*
- (2) *An application for admission for treatment may be made in respect of a patient on the grounds that*
 - (a) *he is suffering from mental illness, severe mental impairment, psychopathic disorder or*

14 Although it should be noted that the Mental Health Act Hospital Order 'route' remains open to the sentencing judge. See section 37 (1A) Mental Health Act 1983 (inserted by para 38 schedule 32 Criminal Justice Act 2003).

15 Criminal Justice Act 2003 sections 225(1)(b), 226(1)(b), 228(1)(b)(i)

16 Criminal Justice Act 2003 section 229(3)

17 Sentence reforms are crowding Jails – Ben Leapman, Sunday Telegraph 11th February 2007

18 BBC News on-line 24th January 2007: <http://news.bbc.co.uk/1/hi/uk/6293225.stm>

19 Prison governors call for fewer jailings not more jails – Alan Travis The Guardian 10th April 2007

mental impairment and his mental disorder is of a nature or degree which makes it appropriate for him to receive medical treatment in a hospital; and

- (b) in the case of psychopathic disorder or mental impairment, such treatment is likely to alleviate or prevent a deterioration in his condition; and
- (c) it is necessary for the health or safety of the patient or for the protection of other persons that he should receive such treatment and it cannot be provided unless he is detained under this section

“Medical treatment” is defined²⁰ as including

nursing, and also includes care, habilitation and rehabilitation under medical supervision:

The Government’s attempts to reform the existing law have met with considerable and to some extent successful opposition, although the final outcome of the legislative battle has yet to be determined. Without engaging in a full narrative of the passage of the Mental Health Bill through the House of Lords, a glance at recent proposals may be instructive. The changes proposed by the Government in the Mental Health Bill in 2006 would have amended the above provision as follows:²¹

- (1) *A patient may be admitted to a hospital and detained there for the period allowed by the following provisions of this Act ... in pursuance of an application made in accordance with this section*
- (2) *An application for admission for treatment may be made in respect of a patient on the grounds that*
 - (a) *he is suffering from mental disorder of a nature or degree which makes it appropriate for him to receive medical treatment in a hospital; and*
 - (b) *...*
 - (c) *it is necessary for the health or safety of the patient or for the protection of other persons that he should receive such treatment and it cannot be provided unless he is detained under this section; and*
 - (d) *appropriate medical treatment is available for him*
- (4) *In this Act, references to appropriate medical treatment, in relation to a person suffering from a mental disorder, are references to medical treatment which is appropriate in his case, taking account of the nature and degree of the mental disorder and all other circumstances of his case.*

A fierce debate ensued on what were said to be the dangers of a patient being detained even where there was no treatment which was likely to alleviate his condition.²² In an attempt to allay these concerns the Government proposed to amend sub-clause 4 by deleting the words “*which is appropriate all other circumstances of his case*”, and replacing them with the following:

... which is likely to alleviate, or prevent a worsening of the disorder or one or more of its symptoms or effects.

This proposal and the original proposed amendment was defeated in the House of Lords. In the version of the Bill now²³ being considered in the House of Commons, sub-clause 4 reads:²⁴

In this Act, references to appropriate medical treatment, in relation to a person suffering from mental

20 Mental Health Act 1983 section 145(1)

925 et seq

21 Mental Health Bill, HL Bill 1 (2006) 7th March 2007, clause 4

23 This article was accepted for publication on 12/04/07.

24 Mental Health Bill, 7th March 2007, clause 5

22 See for example Lords Hansard 19th February 2007 col

disorder, are references to medical treatment which is likely to alleviate or prevent a deterioration in his condition.

In other words, the test reverted to that in the existing Act. However it is of interest that the Government argued that even its original proposed amendment did not imply an intention to detain people with personality disorders who have not committed a crime:²⁵

Nothing could be further from the truth. We hope that abolishing the treatability test will help change attitudes that have limited services available for people with personality disorders and excluded them from available services... We think that the treatability test has inhibited the health service from providing the right care and treatment to the group of people we are talking about. Nothing in the Bill, in case law or in the Government's policy equate detention with medical treatment. Detaining someone is not treatment...

The Government seems to have travelled a long way since Mr Straw's pronouncement in the immediate aftermath of the Russell murders. However there is no doubt that it is proposed to widen the scope of treatment which is to be taken into account. The definition of "medical treatment" is proposed to be changed to read as follows:

*nursing, psychological intervention and specialist mental health habilitation, rehabilitation and care.*²⁶

In other words psychological treatment and techniques are to receive a prominence not previously accorded to them in the Act.

What fate awaits these proposals in Parliament, only time will tell. However governmental thinking still appears to be informed by a belief that persons with personality disorders are denied treatment which is available and effective and is more than mere detention. It is not within the expertise of the writer to say whether or not such a state of affairs exists, but the facts of Mr Stone's case may be instructive. He was not denied such treatment as was available, apart from, for a time, in-patient drug detoxification. In any event this was treatment which he appeared to be seeking: therefore detention to give it would not have been appropriate. Further, not only was he offered this in the end, drug misuse is not a ground on which to diagnose mental disorder. As much is accepted by the Government as being the position under existing law, and this is now potentially reinforced by an opposition amendment to section 1(3) of the Act inserted in the Bill²⁷ in the House of Lords:

(3) For the purposes of subsection (2) above, a person shall not be considered to have a mental disorder as defined in this section solely on the grounds of—

- (a) his substance misuse (including dependence upon, or use of, alcohol drugs);*
- (b) his sexual identity or orientation;*
- (c) his commission, or likely commission, of illegal or disorderly acts;*
- (d) his cultural, religious or political beliefs.*

There was no evidence that the local forensic unit was unwilling to consider admitting Mr Stone should grounds for doing so have been demonstrated. It was more than unfortunate that the unit was denied the chance to make a fully informed decision about Mr Stone's state shortly before the murder by an inadequate communication from a general practitioner. However it could not be said with any certainty that even the correct information would have revealed a clinically justifiable need to detain Mr Stone.

²⁵ Lord Hunt of Kings Heath, Lords Hansard 19th February 2007 col 934

²⁶ Mental Health Bill, 7th March 2007, clause 9

²⁷ Mental Health Bill, 7th March 2007, clause 3

The real issue that concerns the public in a case such as Mr Stone's is whether anything can be done to ensure that someone like him is not able to perpetrate horrific crimes on innocent members of the public. The answer, it might be thought, does not lie within the remit of the mental health service but the law enforcement agencies. The perceived difficulty in relation to dangerous individuals who have not been convicted of offences is a somewhat artificial construct. It is difficult to believe that there are many persons who are known to the statutory agencies to be so dangerous that they would warrant detention to protect the public, but who have not been convicted of at least one serious offence. Mr Stone was certainly not such a person: he had more than one conviction for a serious offence and was regarded within the criminal justice system as being dangerous. In this regard to such cases the sentencing powers and obligations under the Criminal Justice Act 2003 provide a more fruitful means of reassuring the public than the kind of proposal that has been considered, but so far rejected by Parliament. It is at least arguable that, if the events had occurred after the 2003 Act came in to force, Mr Stone would have been eligible for an indefinite sentence and, at the time of his concerning behaviour in July 1996, could have been considered for recall to prison. This may be thought to be a more appropriate means of dealing with cases such as his, than to place the responsibility on mental health services who may have a very limited clinical role to play in them.

The challenge is to ensure that the new powers are used to target those who actually need to be detained indefinitely and not to fill up the prisons with those who do not. It is suggested that this requires the allocation of considerable resources to the criminal justice system, and in particular the probation service, to enable the relevant expertise to be developed and improved. A risk of using the mental health legislation for non-clinical purposes is that the hospitals will become as full as the prisons are now, with the consequent adverse effect on the care and supervision of those already within that system, to the detriment not only of the patients themselves, but to the public who deserve properly focussed and informed protection.